PRIMARY AGENCY:

Department of Health and Human Services U.S. Public Health Service

SUPPORT AGENCIES:

Department of Agriculture
Department of Defense
Department of Justice
Department of Transportation
Department of Veterans Affairs
Agency for International Development
American Red Cross
Environmental Protection Agency
Federal Emergency Management Agency
General Services Administration
National Communications System
U.S. Postal Service

I. INTRODUCTION

A. Purpose The purpose of this Emergency Support Function (ESF) is to provide United States Government coordinated assistance to supplement State and local resources in response to public health and medical care needs following a significant natural disaster or ma n-made event. Assistance provided under ESF #8 - Health and Medical Services, is directed by the Department of Health and Human Services (HHS) through its Executive Agent, the Assistant Secretary for Health (ASH), who heads the United States Public Heal th Service (PHS). Resources will be furnished when State and local resources are overwhelmed and medical and/or public health assistance is requested from the Federal Government. B. Scope ESF #8 involves supplemental assistance to State and local governments in identifying and meeting the health and medical needs of victims of a major emergency or disaster. This support is categorized in the following functional areas:

1. Assessment of health/medical needs;
2. Health surveillance;
3. Medical care personnel;
4. Health/medical equipment and supplies;

5. Patient evacuation;
6. In-hospital care;
7. Food/drug/medical device safety;
8. Worker health/safety;
9. Radiological Hazards;
10. Chemical Hazards;
11. Biological Hazards;
12. Mental health;
13. Public health information;
14. Vector control;
15. Potable water/wastewater and solid waste disposal; and
16. Victim identification/mortuary services.

The PHS in its primary agency role for ESF #8, directs the provision of United States Government provided health and medical assistance to fulfill the requirements identified by the affected State/local authorities having jurisdiction. Included in ESF # 8 is overall public health response, and the triage, treatment and transportation of victims of the disaster, and the evacuation of patients out of the disaster area, as needed, into a network of Military Services,

Veterans Affairs, and pre-enrolled non-Federal hospitals located in the major metropolitan areas of the United States. The intent of ESF #8 is to supplement and assist the State/local governments affected by the disaster by utilizing resources primaril y available from the following sources:

1. Resources available within HHS from PHS, Administration on Children and Families, Social Security Administration, Health Care Financing Administration, and the Administration on Aging.
2. Supporting departments and agencies to ESF #8.
3. Resources are available from the National Disaster Medical System (NDMS). NDMS is Nationwide medical mutual aid network between the Federal and non-Federal sectors that includes medical response, patient evacuation, and definitive medical care. At the Federal-level, it is a partnership between HHS, Department of Defense (DOD), Department of Veterans Affairs (VA), and the Federal Emergency Management Agency (FEMA).
4. Specific non-Federal sources such as major pharmaceutical suppliers, hospital supply vendors, the National Funeral Directors Association, certain international disaster response organizations, Department of Health and Welfare Canada (HWC), etc.

II. POLICIES

1. ESF #8 will be implemented upon the appropriate State-level

request for assistance following the occurrence of a significant natural disaster or man-made event and determination has been made that a Federal response is warranted.

2. The ASH, HHS/PHS, is responsible for activating and directing the activities for ESF #8. The lead policy official for ESF #8 supporting the ASH is the Deputy Assistant Secretary for Health (DASH). The Office of the Assistant Secretary for Health /Office of Emergency Preparedness (OASH/OEP) is the action agent and is responsible for coordinating the implementation of ESF #8 and providing staff support to the HHS policy officials. The PHS Regional Health Administrator (RHA) is the operating age nt and is responsible for directing Regional ESF #8 activities.
3. The colocated National HHS Emergency Operating Center (EOC)/NDMS Operations Support Center (OSC) (HHSEOC/NDMSOSC) will provide liaison between the Federal Government Headquarters and appropriate Regional officials in the response structure at the disaster scene for the coordination of Federal health and medical assistance to meet the requirements of the situation. The HHSEOC/NDMSOSC will coordinate and facilitate the overall ESF #8 response.
4. In accordance with assignment of responsibilities in ESF #8, and further tasking by the primary agency, each support organization participating under ESF #8 will contribute to the overall response but will retain full control over its own resources and personnel.
5. ESF #8 is the primary source of public health and medical response/information for all Federal officials involved in response operations.
6. All national and regional organizations (including other ESFs) participating in response operations will report public health and medical requirements to their counterpart level (national or regional) of ESF #8.
7. ESF #8 will not release medical information on individual patients to the general public to ensure patient confidentiality protection.
8. Appropriate information on casualties/patients will be provided to the American Red Cross (ARC) for inclusion in the Disaster Welfare Information (DWI) System for access by the public.
9. Requests for recurring reports of specific types of medical and public health information will be submitted to ESF #8 as soon as information requirements are identified to enable ESF #8 to develop and implement procedures for providing those recurri ng Situation Reports (SITREPS).
10. The primary Joint Information Center (JIC), established in support of the Federal Response Plan, hereafter referred to as the Plan, will be authorized to release general medical and public health response information to the public. Other JICs may a lso release general medical and public health response

information at the discretion of the Federal Coordinating Officer's (FCO's) Lead Public Affairs Officer.

III. SITUATION

A. Disaster Condition A significant natural disaster or man-made event that overwhelms the affected State would necessitate both Federal public health and medical care assistance. For example, casualty estimates for a major earthquake could range from 12,000 to more than 200,000, depending on population density, quality of building construction, and the location, time, magnitude and duration of the earthquake. The sudden onset of such a large number of victims would stress a State medical system necessitating tim e-critical assistance from the Federal government. Such a natural disaster would also pose certain public health threats, including problems related to food, vectors, water, wastewater,solid waste, and mental health effects.

Hospitals, nursing homes, pharmacies and other medical/health care facilities may be severely structurally damaged or destroyed. Those facilities which survive with little or no structural damage may be rendered unusable or only partially usable becaus e of a lack of utilities (power, water, sewer), because staff are unable to report for duty due to personal injuries and/or damage/disruption of communication and transportation systems. Medical and health care facilities which remain in operation and have the necessary utilities and staff will probably be overwhelmed by the "walking wounded" and seriously injured victims who are transported there in the immediate aftermath of the occurrence. In the face of massive increases in demand and the damage sustained, medical supplies (including pharmaceuti cals) and equipment will probably be in short supply. Most health care facilities usually maintain only a small inventory stock to meet their short term normal patient load needs. Disruptions in local communications and transportation systems co uld prevent timely resupply.

Uninjured persons who require daily medications such as insulin, antihypertensive drugs, and digitalis may have difficulty in obtaining these medications because of damage/destruction of normal supply locations and general shortages within the disaster a rea.

Although other disasters such as hurricanes, floods, etc., may not generate the casualty volume of a major earthquake, there will be a noticeable emphasis on relocation, shelters, vector control, and returning water, wastewater, and solid waste facili ties to operation.

A major emergency resulting from an explosion or toxic gas release could occur that might not damage the local medical system. However, such an event could produce a large concentration of

specialized injuries that could overwhelm the State and local me dical system. B. Planning Assumptions

1. Resources within the affected disaster area will be inadequate to clear casualties from the scene or treat them in local hospitals. Additional mobilized Federal capabilities will urgently be needed to supplement and assist State and local governmen ts to triage, and treat casualties in the disaster area and then transport them to the closest appropriate hospital or other health care facility. Additionally, medical resupply will be needed throughout the disaster area. In a major disaster, operati onal necessity will probably require the further transportation of patients, probably by air, to the nearest metropolitan areas with sufficient concentrations of available hospital beds where patient needs can be matched with the necessary definitive me dical care.
2. Damage to chemical and industrial plants, sewer lines, and water distribution systems and secondary hazards such as fires will result in toxic environmental and public health hazards to the surviving population and response personnel including expos ure to hazardous chemicals, and contaminated water supplies, crops, livestock, and food products.
3. The damage and destruction of a catastrophic natural disaster will produce urgent needs for mental health crisis counseling for disaster victims and response personnel.
4. Assistance in maintaining the continuity of health and medical services will be required.
5. Disruption of sanitation services and facilities, loss of power, and massing of people in shelters may increase the potential for disease and injury.

IV. CONCEPT OF OPERATIONS

A. General Upon notification of a significant natural disaster or man-made event, PHS (as lead agency) will alert the National ESF #8 Crisis Action Team (CAT) to assemble in the HHS EOC in the Parklawn Building in Rockville, Md. The ASH, DASH, PHS Agency Emergency Coordinators (AECs), and appropriate PHS RHAs and HHS Regional Directors (RDs) will be notified.

The ASH will direct the activities of ESF #8 and will activate the NDMS as needed.

Pre-identified personnel will be alerted to meet requirements for representing ESF #8 on the:

1. Catastrophic Disaster Response Group (CDRG) at FEMA Headquarters;
2. Emergency Support Team (EST) at FEMA Headquarters;

3. National ESF #8 Emergency Response Team (ERT);
4. Regional ESF #8 EOC;
5. Regional Operations Center (ROC) at the FEMA Regional Office; and
6. Advance Element of the Emergency Response Team (ERT-A).

All support agencies/organizations will be notified and tasked to provide 24-hour representation as necessary. Each support agency/organization is responsible for insuring that sufficient program staff is available to support the HHSEOC/NDMSOSC and to c arry out the activities tasked to their agency/organization on a continuous basis. Individuals representing agencies/organizations who are staffing the HHSEOC/NDMSOSC will have extensive knowledge of the resources and capabilities of their respective ag encies/organizations and have access to the appropriate authority for committing such resources during the activation.

National ESF #8 will provide liaison and long distance high frequency radio support to Regional ESF #8 to facilitate direct communications between Regional ESF #8 and National ESF #8. The National ESF #8 ERT will be deployed as necessary to assist Regi onal ESF #8 in establishing and maintaining effective coordination within the disaster area.

Regional ESF #8 will be established and will maintain coordination with the appropriate State medical and public health officials and organizations to obtain current medical and public health assistance requests. It is anticipated that most requests wil l be made by telephone, radio or face-to-face conversations rather than by formally written requests.

Regional ESF #8 will be supported by the regional Joint Medical Mobilization Office (JMMO) or other entity designated by the DOD Defense Coordinating Officer (DCO) to coordinate civil authority requests for military resource support within the disaster a rea. Regional ESF #8 will also be assisted by those other support agencies as contained in the Regional ESF #8 appendices.

Regional ESF #8 will utilize locally available health and medical resources to the extent possible to meet the needs identified by State/local authorities. National ESF #8 will meet the additional requirements primarily from pre-arranged sources from th roughout the United States and Canada.

Throughout the response period, ESF #8 will evaluate and analyze medical and public health assistance requests and responses, and develop and update assessments of medical and public health status. All requests from appropriate State authoriti es for medical and

public health assistance will be assumed to be valid. Upon receiving conflicting or questionable requests, ESF #8 will attempt to confirm the actual need. ESF #8 will maintain accurate and extensive logs to support after-action repor ts and other documentation of the disaster conditions.

ESF #8 will develop and provide medical and public health situation reports to the CDRG, EST, the FCO's Reports Officer, the primary JIC, and organizations with a need for recurring reports of specific types of information including other ESFs, Federal a gencies, and the State upon request. Information will be disseminated by all available means including FAX, telephone, radio, memoranda, display charts and maps, and verbal reports at meetings and briefings. B. Organization

1. National-Level Response Support Structure
   ESF #8 response will be activated and directed by the ASH/HHS/PHS. The HHSEOC will become operational, and upon activation of NDMS, the NDMSOSC will also become operational and these centers will co-locate at the OASH/OEP facility in Rockville, Md. The HHSEOC/NDMSOSC will consist of a core of Federal agencies which will be supplemented by other national-level organizations, governmental and private, as the situation dictates. During the initial activation the principal core staff will consist of a predesignated PHS CAT and the following officials or their representatives:
   a. ASH/HHS/PHS;
   b. Assistant Secretary of Defense (Health Affairs), DOD;
   c. Chief Medical Director, Veterans Health Administration (VHA), VA; and
   d. Director, FEMA.

   Additional supporting agencies and organizations will be alerted and will either be tasked to provide a representative to the HHSEOC/NDMSOSC or to provide a representative who will be immediately available via telecommunications means (telephone, FAX, conference calls, etc.) to provide support.

   PHS will identify and provide representatives to represent both HHS/PHS and National ESF #8 on the CDRG and the FEMA EST. PHS also will dispatch as needed, emergency response coordinators and the National ESF #8 ERT to the disaster area to support the lead RHA having responsibility for the Regional ESF #8.

   Coordination of ESF #8 will be centralized at the HHSEOC/NDMSOSC.

As needed, special advisory groups of health/medical subject matter experts will be assembled and consulted by National ESF #8.

2. Regional-Level Response Structure
   a. The RHA is the lead for the Regional ESF #8 health and medical response and will establish a Regional ESF #8 EOC and will provide administrative support to the regional response activities. The HHS RD will assist the RHA by coordinating human ser vices support required from the other HHS operating divisions located within the Region.
   b. The lead of Regional ESF #8 will represent ESF #8 in its dealings with the FCO and will maintain liaison with the FCO, the appropriate State/local health and medical officials, National ESF #8, and the HHS RD.
   d. Regional ESF #8 will have appropriate representative (s) present or available by telephone or radio at the Regional ESF #8 EOC, and additionally at the FEMA ROC and/or the FEMA Disaster Field Office (DFO) as required by the FCO on a 24-hour basis for the duration of the emergency response period. Other representatives of the lead/support agencies will be available to staff the ROC and/or the DFO upon request of the lead of Regional ESF #8.

C. Notification

1. Upon the occurrence of a potential major natural disaster or man-made event, FEMA Headquarters will notify the ESF #8 action agent (OASH/OEP). The affected FEMA Region will notify the PHS RHA. There are a number of ways ESF #8 could initially be notified by FEMA. This notification would probably be made via telephone, FAX, or digital pagers. Such notification could be to: advise of the potential disaster; convene the CDRG; request an ESF #8 representative to deploy as a regional ERT member; e stablish the EST at FEMA Headquarters; or to pass a request from regional or State officials requesting activation of NDMS.
2. OASH/OEP will notify the ASH and request activation of ESF #8. OASH/OEP will alert their CAT that will notify the lead of Regional ESF #8 by telephone or radio, if possible. If the RHA or his/her appropriate representative cannot be contacted, the HHS RD will be notified and requested to advise the Regional ESF #8 lead. If the HHS RD cannot be contacted, the ESF #8 lead of an adjacent region will be contacted and requested to assist in notifying and establishing the Regional ESF #8 in the disaster area.

3. The OASH/OEP CAT also will notify all other National ESF #8 members by the most expeditious communication method.
4. Upon notification, ESF #8 members will notify their parent agencies/organizations. ESF #8 members will report to the appropriate location(s) as directed (such as HHSEOC/NDMSOSC, FEMA Headquarters, etc.) and Regional ESF #8 members will rep ort to the appropriate location(s) as directed (such as the ROC or DFO).

D. Response Actions

1. Initial Actions Following Potential Catastrophic Disaster

The HHSEOC will become operational within 2 hours of notification. Until the Regional ESF #8 becomes operational, the collection, analysis, and dissemination of requests for medical and public health assistance will be the responsibility of National ESF #8 with the assistance of the PHS region. Upon declaration by the RHA that the Regional ESF #8 EOC is operational, the major responsibilities for requests for medical and public health assistance will be transferred to Regional ESF #8. National ESF #8 will conduct the following actions while bringing ESF #8 to a fully operational status.
a. Upon notification of the occurrence of a potential major emergency or disaster, the lead of National ESF #8 (the ASH) will request PHS and support agencies/organizations to initiate action immediately to identify and report the potentia l need for Federal health and medical support to the affected disaster area in the following functional areas:

(1) Assessment of Health/Medical Needs Lead PHS Agency: OASH/OEP-NDMS: An assessment team will be mobilized and deployed to the disaster area to assist in determining specific health/medical needs and priorities. The assessment team composition will be jointly determined by the a ction agent and the operating agent based on the type and location of the emergency.
(2) Health Surveillance Lead PHS Agency: Centers for Disease Control: Assist in establishing surveillance systems to monitor the general population and special high-risk population segments; carry out field studies and investigations; monitor injury and disease patt erns and potential disease outbreaks; and provide technical assistance and consultations on disease and injury control measures and precautions.
(3) Medical Care Personnel Lead PHS Agency: OASH/OEP-NDMS: Provide Disaster Medical Assistance Teams (DMATs) to assist in providing care for ill or injured victims at the site of a disaster or

emergency. DMATs can provide triage, medical or surgical stabilization, and c ontinued monitoring and care of patients until they can be evacuated to locations where they will receive definitive medical care. Specialty DMATs can also be deployed to address mass burn injuries, pediatric trauma, chemical injury or contamination, et c. In addition to DMATs, active duty, reserve, and National Guard medical units for casualty clearing/staging and other missions will be deployed as needed. Individual clinical health and medical care specialists may be provided to assist State and local personnel.

(4) Health/Medical Equipment and Supplies Lead PHS Agency: OASH/OEP-NDMS: Provide health and medical equipment and supplies, including pharmaceutical, biologic products, and blood and blood products in support of NDMS DMAT operations and for restocking health and medical care facilities in ar eas affected by major disasters or emergencies.

(5) Patient Evacuation Lead PHS Agency: OASH/OEP-NDMS: Provide for movement of seriously ill or injured patients from the area affected by a major disaster or emergency to locations where definitive medical care is available. NDMS patient movement will primari ly be accomplished utilizing fixed wing aeromedical evacuation (AE) resources of the DOD; however, other transportation modes may be used, as circumstances warrant.

(6) In-Hospital Care Lead PHS Agency: OASH/OEP-NDMS: Provide definitive medical care to victims who become seriously ill or injured as a result of a major domestic disaster or emergency. For this purpose, the NDMS has established and maintains a nationwide ne twork of over 105,000 voluntarily pre-committed non-Federal acute care hospital beds in the 107 largest United States metropolitan areas.

(7) Food/Drug/Medical Device Safety Lead PHS Agency: Food and Drug Administration: Assure the safety and efficacy of regulated food, drug, biologic products, and medical devices following major disasters or emergencies. Arrange for seizure, removal, and/or destruction of c ontaminated or unsafe products.

(8) Worker Health/Safety Lead PHS Agency: Centers for Disease Control: Assist in monitoring health and well-being of emergency workers; perform field investigations and studies addressing worker health and safety issues; and provide technical assistance and consult ation on worker health and safety measures and precautions.

(9) Radiological Hazards Lead PHS Agency: Centers

for Disease Control: Assist in assessing health and medical effects of radiological exposure on the general population and on high-risk population groups; conduct field investigations, including collection and analys is of relevant samples; advise on protective actions related to direct human and animal exposure, and on indirect exposure through radiologically contaminated food, drugs, water supply, and other media; and provide technical assistance and consultation on medical treatment of radiologically injured victims.

(10) Chemical Hazards Lead PHS Agency: Centers for Disease Control: Assist in assessing health and medical effects of chemical exposure on the general public and on high-risk population groups; conduct field investigations, including collection and laboratory analysis of relevant samples; advise on protective actions related to direct human and animal exposure and on indirect exposure through chemically contaminated food, drugs, water supplies, and other media; and provide technical assistance and consultatio ns on medical treatment of chemically injured victims.

(11) Biological Hazards Lead PHS Agency: Centers for Disease Control: Assist in assessing health and medical effects of exposure to biologic agents on the general population and on high-risk population groups; conduct field investigations, including the collec tion and laboratory analysis of relevant samples; advise on protective actions related to direct human and animal exposure, and on indirect exposure through biologic agent contamination of food, drugs, water supplies, and other media; and provide technic al assistance and consultations on medical treatment of victims injured by biologic agents.

(12) Mental Health Lead PHS Agency: Alcohol, Drug Abuse, and Mental Health Administration: Assist in assessing mental health needs; provide mental health training materials for disaster workers; assist in arranging training for mental health outreach worke rs; assess adequacy of applications for Federal crisis counseling grant funds; address worker stress issues and needs through a variety of mechanisms.

(13) Public Health Information Lead PHS Agency: Centers for Disease Control: Assist by providing public health and disease and injury control and prevention information that can be transmitted to members of the general public who are located in or near areas affected by a major disaster or emergency.

(14) Vector Control Lead PHS Agency: Centers for Disease Control: Assist in assessing the threat of vector-borne diseases following major disasters or

emergencies; conduct field investigations, including the collection and laboratory analysis of relevant samples ; provide vector control equipment and supplies; provide technical assistance and consultation on protective actions regarding vector-borne diseases; and provide technical assistance and consultation on medical treatment of victims of vector-borne diseas es.

(15) Potable Water/Wastewater and Solid Waste Disposal Lead PHS Agency: Indian Health Service: Assist in assessing potable water and wastewater/solid waste disposal issues; conduct field investigations, including collection and laboratory analysis of relevant samples; provide water purification a nd wastewater/solid waste disposal equipment and supplies; and provide technical assistance and consultation on potable water and wastewater/solid waste disposal issues.

(16) Victim Identification/Mortuary Services Lead PHS Agency: OASH/OEP-NDMS: Assist in providing victim identification and mortuary services, including NDMS Disaster Mortuary Services Teams (DMORTs); temporary morgue facilities; victim identification utilizing latent fingerprint, forensi c dental, and/or forensic pathology/anthropology methods; processing, preparation, and disposition of remains.

b. National ESF #8 will also initiate through the appropriate command and control systems, as necessary, the following actions to alert certain elements of the health and medical system to either respond or be prepared to respond if needed:

(1) Alert and deploy National ESF #8 representative(s) to National EST at FEMA Headquarters in Washington, DC;

(2) Alert National ESF #8 representative(s) to be on "stand-by" to deploy to the disaster area as a member of the National ESF #8 ERT;

(3) Alert and deploy National ESF #8 Emergency Response Coordinator(s) (ERC) to the disaster area to provide liaison and support to Regional ESF #8. ERCs will be self-contained as much as possible (tents, sleeping bags, food, etc.) and will pro vide some long distance high frequency radio communications support for direct connectivity between the Regional and National ESF #8;

(4) Request PHS/OEP to alert NDMS DMATS on a "stand-by" basis;

(5) Through its DOD representative, alert Armed Services Medical Regulating Office (ASMRO) to prepare to receive hospital bed availability reports. ASMRO will establish an appropriate reporting window;

(6) Through VA, DOD representatives, and appropriate VA and Services command and control systems, alert local NDMS Federal Coordinating Centers (FCCs) to obtain bed availability reports from the participating non-Federal hosp itals and report bed status to ASMRO;
(7) Alert PHS Supply Service Center, Defense Logistics Agency (DLA), HWC and other pre-identified sources of medical supplies to be on a "stand-by" basis;
(8) Alert national-level transportation and communications support agencies/organizations to be on a "stand-by" basis;
(9) Determine from ESF #5 - Information and Planning, the geographic area affected by the disaster and also obtain weather information for the disaster area including present conditions, the 24-hour forecast, and the long-range forecast; and
(10) Request that PHS/National Institutes of Mental Health (NIMH) initiate action to implement mental health support activities.

c. National ESF #8 primary and support agency/organization members will report to the HHSEOC/NDMSOSC and convene within 2 hours following notification. Alternatively, ESF #8 members may be directed to report to their usual offices within 2 hours a nd thereafter maintain continuous telephone communication with National ESF #8.
d. The NDMSOSC DOD representative will activate the national-level DOD support network as required. This alerting may include, but not be limited to: Department of the Army, the Directorate of Military Support (DOMS); the Surgeons General of the A rmy, Navy, and Air Force; the United States Transportation Command (USTRANSCOM); the Air Mobility Command (AMC); the National Guard Bureau (NGB); ASMRO; Forces Command (FORSCOM); the United States Atlantic Command (USLANTCOM); the United States Pacific C ommand (USPACOM); the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS); the Medical Readiness Division, Office of the Joint Chiefs of Staff (J-4/JCS); and other appropriate DOD components. DOMS, in coordination with the Services and JCS executive agents (ie., HQUSAF/SG for ASMRO) will in turn, notify service FCCs and other Service components as appropriate.

2. Continuing Actions

a. Situation Assessment The National ESF #8 staff will continuously acquire and assess information about the disaster situation. The staff will continue to attempt to identify the nature and extent of health and medical problems, and establish appropriate monitoring and su rveillance of the situation to obtain valid ongoing information. National ESF

#8 will primarily rely on information from the disaster area that is furnished by Regional ESF #8. Other sources of information may include National ESF #8 s upport agencies/organizations; various Federal officials in the disaster area; State health officials; State Emergency Medical Services (EMS) authorities; State disaster authorities; or the responsible jurisdiction in charge of the disaster scen e. Also, information may be acquired from Federal officials outside of the disaster area such as local NDMS FCCs, FEMA Regional Offices, and PHS Regional Offices.

In the early stages of a disaster response, it may not be possible to fully assess the situation and verify the need for the level of assistance that is being requested. In such circumstances, it shall be the responsibility of National ESF #8 and Re gional ESF #8 to collectively decide whether to authorize assistance. Every attempt shall be made to verify the need before providing assistance. However, it may be necessary to proceed with assistance on a limited basis before verifications a re obtained. In such a situation, the ESF #8 will use common sense, be flexible, and responsive to meeting perceived time critical needs.

Because of the potential complexity of the health and medical response issues/situations, conditions may require special advisory groups of subject matter experts to be assembled by National ESF #8 to review health/medical intelligence information and to advise on specific strategies to employ to most appropriately manage and respond to a specific situation.

b. Activation of Health/Medical Response Teams By direction of the ASH, health personnel/teams from PHS will be deployed as needed and appropriate medical and public health (including environmental health) assistance will be provided. NDMS DMAT teams will be activated and deployed as needed. PHS/OEP will respond to the direction by arranging for alerting, activation, appointment to Federal status (where appropriate) and deployment of NDMS DMATs. The PHS/OEP representative also will coordinate with other NDMSOSC agency representatives who w ill arrange for the necessary transportation and logistic support for the DMATs. DMATs may be activated for provision of patient reception, patient staging, casualty clearing, or other medical care activities in meeting the needs of the situation.

Certain military medical units, including active duty, National Guard and Reserve, may be tasked to deploy to support ESF #8 requirements. These requirements will be coordinated with

the NDMSOSC DOD representative who will coordinate with DOMS to a ctivate and deploy the necessary military units.

c. Coordination of Medical Transportation Requests
Arrangements for medical transportation should be made at the lowest levels possible. Normally local transportation requirements are to be handled by local authorities. If it is determined by Regional ESF #8 that local or regional resources are inad equate to meet the requirements, a request for Federal medical transportation assistance will be worked at the National ESF #8 level and will be referred to representatives from DOD, Department of Transportation (DOT), General Services Administration (GS A), Department of Agriculture (USDA), and United States Postal Service (USPS) to initiate assistance by their respective agencies, including arrangements for aeromedical evacuation. Patient regulation will be the responsibility of ASMRO.

d. Coordination of Requests for Medical Facilities
Arrangements for medical facilities are primarily a local function. Requests for additional assistance should first be referred to State authorities. Requests by State officials for Federal aid for NDMS hospital support should be routed through Re gional ESF #8 to the NDMSOSC. The NDMSOSC will verify the request and refer it to the DOD and VA representatives. The VA and DOMS, through its Service representatives, will notify NDMS FCCs to activate area operations/patient reception plans. HQUSAF will alert ASMRO regarding NDMS activation. ASMRO will establish and disseminate appropriate bed reporting instructions to FCCs. Further, the 57th Aeromedical Evacuation Squadron/Aeromedical Evacuation Control Center, Scott Air Force Base, Illino is (hereafter referred to as the AECC [formerly the Patient Airlift Center]) will provide appropriate patient reception/patient arrival information to ASMRO and to the local FCCs. Local FCCs, through their patient reception teams, will distribute arriv ing patients to specific NDMS participating hospitals based upon the patients' need and facility capability.

e. Coordination of Requests for Aeromedical Evacuation of Patients from the Disaster Area

(1) State and local health/medical authorities identify the need for patient evacuation support from the disaster area. The requirement for aeromedical evacuation is communicated through Regional ESF #8 to the NDMSOSC. The DOD representativ e in the NDMSOSC, in turn, will coordinate with the appropriate commands such as FORSCOM,

USTRANSCOM, USLANTCOM, USPACOM, and/or HQAMC Command Centers. The agency contacted will then coordinate with the appropriate supporting command to obtain the neede d support.

(2) The concept of operation is for local authorities to operate Casualty Collection Points (CCPs) that will feed into State operated Regional Evacuation Points (REPs). ESF #8 will coordinate the "hand-off" of patients from the REPs into the NDMS patient evacuation system.

(3) Patient regulating is the responsibility of the ASMRO. Because the movement of patients is based upon the availability of hospital beds, ASMRO will receive patient requirements from the disaster area and regulate patients to destination reception areas reporting available beds. Regional ESF #8 will establish a Patient Reporting Activity (PRA) to report the number of patients to ASMRO requiring movement out of the area. Patients will be reported in the specified contingency categories . FCCs will likewise report available beds in the same contingency categories. Once the regulating decision is made, ASMRO will pass it to the PRA and the receiving FCCs. After receipt by the PRA, Regional ESF #8 will coordinate with the Stat e to have the patients moved.

(4) AE resources will be deployed based on the nature of the emergency or disaster and estimated length of support requirement. In a limited operation, support may be restricted to the providing of Aeromedical Evacuation Crew Members (A ECM), airlift, and/or liaison personnel with centralized management remaining with the AECC, Scott Air Force Base. In a larger or more prolonged event which may require sustained support, elements of the Tactical Aeromedical Evacuation System (TAES), to include an Aeromedical Evacuation Casualty Element (AECE), Mobile Aeromedical Staging Facility (MASF), Aeromedical Evacuation Liaison Team (AELT), and AECMs may be deployed to the region. When deployed, the AECE will provide regional control for the AE elements with overall responsibility for continental United States (CONUS) AE operations remaining with the AECC, Scott Air Force Base. Outside the continental United States (OCONUS), overall responsibility will rest with the appropr iate military command (CINCLANT or CINCPAC) having military support responsibility for the geographic area of the disaster/emergency.

(a) An AELT could deploy to the REPs to provide a direct HF radio communications link and immediate coordination between the REP originating the requirements for aeromedical evacuation and the AECC. The primary mission of the AELT is to

coordinate patient movement requests and the movement schedule between the AECC and the REP.
(b) The AECC is the operations center responsible for mission planning, coordinating, and management of the disaster area AE operations. The AECC establishes and is the focal point for communications and provides the source of control a nd direction for disaster area AE forces.
(c) The MASF is a mobile, tented, temporary staging facility deployed to provide supportive care and administration. It does not have beds or cots. Since it has no organic patient carrying vehicles, it is normally located near runways, taxiways, or airfields.
(d) The AECMs provide inflight supportive medical care aboard AE mission directed aircraft.
(e) Control teams will be deployed to identify the closest appropriate airhead to a REP that can handle the AE aircraft, normally C-9 or C-130. Aeromedical staging capability (utilizing a joint operation between military MASFs and NDMS DM ATS) will be established near the runways or taxiways of the designated airfield or forward operating base. The regulated patients are then moved from the REP to the aeromedical staging location for entrance into the AE system and movement to the regulated destination.
(f) The AELT, AECC, and MASF have equipment and personnel to establish a HF radio network in support of the system. The AECC functions as the net control for the various elements. The following message formats are used throughout the A ES, using specific portions of the AMC Form 801, Tactical Aeromedical Evacuation Mission Message.
(1) AE Support Request Message (Alpha Message) - The Alpha Message starts a patient movement request and is originated by an AELT. Pertinent information concerning the patient movement is gathered by the liaison official and transmitted by radio operator to the AECC and MASF.
(2) AE Support Response Message (Bravo Message) - The Bravo Message is originated by the AECC. When all information concerning the evacuation aircraft is obtained from the ALCC, this information and other applicable data are transcr ibed onto the Bravo section of the AMC Form 801, and then transmitted by radio operator to the MASF and the AELT.
(3) AE Support Confirmation Message (Charlie Message) - The Charlie Message is originated by the MASF. The patients are transported from the REP to the MASF. Assigned MASF personnel administratively process and stabilize the patien ts for tactical

aeromedical evacuation. Upon aircraft departure, the MASF radio operator transmits the pertinent information that has been transcribed onto the Charlie section of the AMC Form 801, to the AECC and the AELT.

(g) If AE elements are not deployed to the disaster area, personnel/medical facilities reporting patient movement requirements should be prepared to provide as much medical information on patients as is known, e.g. current condition, diagno sis, vital signs, any special equipment requirements, etc. A point of contact should be provided so the AECC can obtain any additional information needed to prepare for the mission.

(h) If State/local authorities request patient evacuation but are unable to establish REPs and/or CCPs, ESF #8 will deploy the necessary additional medical force structure to facilitate the lowest echelon level of care required to successful ly accomplish the mission.

f. Coordination for Obtaining, Assembling, and Delivering Medical Equipment and Supplies to the Disaster Area Representatives of PHS, VA, DOD, DOT, and GSA will coordinate arrangements for the procurement and transportation of medical equipment and supplies to the disaster area. A "push" concept will be employed when feasible to expedite medical resupply t o the disaster area from pre-identified medical supply caches. Included in this response will be the PHS requested support, as needed, of certain medical supplies from HWC.

g. Coordination of Requests for Reimbursement Federal agencies and other organizations which are tasked by PHS to support ESF #8 are eligible for reimbursement. All Federal agencies which are tasked will be reimbursed by FEMA directly, typically through a Standard Form 1080 or 1081, the O n-Line Payments and Collection System, or a cash disbursement. Reimbursement of non-Federal entities will be accomplished by other mechanisms. Those officials authorized to approve expenditures should validate the reimbursement requests and ensure that all requests cite and are relevant to ESF #8.

h. Communications National ESF #8 will establish communications necessary to effectively coordinate assistance. At a minimum, National ESF #8 will be expected to maintain communication with the following: Regional ESF #8; the FCO; EST; State health/medical officials as necessary; PHS AECs; DOMS; ASMRO; AMC; and local NDMS FCCs.

As the situation dictates, other agencies such as: FEMA Regional Offices and PHS Regional Offices, also the appropriate centers of the United States Geological Survey (USGS): Natio nal Hurricane Center (NHC); National Earthquake Center (NEC); and the Severe Weather Center (SWC). A variety of communications networks and organizations will be utilized to effect these communications including the public switched telephone ne twork, the Federal Telecommunications System (FTS), and various high frequency radio networks coordinated by FEMA and the National Communications System (NCS). Additionally, amateur radio frequencies and networks and the United States Army Military Affi liate Radio System (MARS) will be utilized to the extent necessary to help meet the communications requirements. DOD units employed in support of this ESF #8 will utilize their organic communications equipment and preassigned fr equencies to facilitate their internal communications requirements.

i. Information Requests Requests for information may be received at ESF #8 from various sources, such as the media and the general public, and they will be referred to the appropriate agency or JIC for response.

j. Journal of Activities A journal of ESF #8 activities shall be maintained by the senior representative of each of the participating agencies. Entries should be made in the journal for each major action, occurrence, or event. OASH/OEP will, upon completion of the emerg ency, review the separate journals and prepare a summary after action report. The after action report, which summarizes the major activities of ESF #8, will identify key problems, indicate how they were solved, and make recommendations for improving res ponse operations in subsequent activations. Support agencies/organizations will assist in the preparation of the after action report and endorse the final report.

E. Intra-State Actions Regional ESF #8, supported by National ESF #8, will collaborate with the identified State health/medical coordinator(s), whose functions include working issues such as:

1. Assessment of health/ medical needs;
2. Health surveillance;
3. Medical care personnel;
4. Health/medical equipment and supplies;
5. Patient evacuation;
6. In-hospital care;
7. Food/drug/medical device safety;
8. Worker health/safety;

9. Radiological Hazards;
10. Chemical Hazards;
11. Biological Hazards;
12. Mental health;
13. Public health information;
14. Vector control;
15. Potable water/wastewater and solid waste disposal; and
16. Victim identification/mortuary services.

V. RESPONSIBILITIES

A. Primary Agency: Department of Health and Human Services, U.S. Public Health Service

1. Provide leadership in directing, coordinating, and integrating the overall Federal efforts to provide medical and public health assistance to the affected area.
2. Direct the activation of NDMS and the staffing of the NDMSOSC as necessary to support the emergency response operations.
3. Direct the activation and deployment of health/medical personnel, supplies, and equipment in response to requests for Federal health/medical assistance.
4. Coordinate the evacuation of patients from the disaster area when evacuation is deemed appropriate by State authorities.
5. Provide human services assistance under the direction of the HHS RD to ESF #8 and other ESFs as necessary.

B. Support Agencies

1. Department of Agriculture

   Assist Federal health and medical response operations by providing support with personnel, equipment, food, and supplies. This support will be coordinated through the Forest Service Fire and Aviation Management Office (located in Washington, DC) and the National Interagency Coordination Center (NICC) located at Boise, Idaho. Support will primarily be for communications and aircraft and the establishment of base camps for deployed Federal health and medical teams in the disaster area.

2. Department of Defense

   a. Alert ASMRO to provide DOD NDMS FCCs (Army, Navy and Air Force) and VA NDMS FCCs reporting/regulating instruction to support disaster relief efforts.

   b. Alert DOD NDMS FCCs to activate NDMS area operations/patient reception plans; initiate bed reporting based on ASMRO instructions.

   c. In coordination with NDMSOSC, evacuate and manage patients as required from the disaster area to NDMS patient

reception areas.
d. In coordination with DOT and other transportation support agencies, transport medical personnel, supplies and equipment into the disaster area.
e. Provide logistical support to health/medical response operations.
f. Provide active duty, reserve and National Guard medical units for casualty clearing/staging and other missions as needed including aeromedical evacuation.
g. Coordinate patient reception and management in NDMS areas where military treatment facilities serve as local NDMS FCCs.
h. Provide military medical personnel to assist PHS in activities for the protection of public health (such as food, water, wastewater, solid waste disposal, vectors, hygiene, and other environmental conditions).
i. Provide available DOD medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims.
j. Provide available emergency medical support to assist in the support of State/local governments within the disaster area. Such services may include triage, medical treatment, and the utilization of surviving DOD medical facilities within the dis aster area.
k. Provide assistance in managing human remains including victim identification and disposition.
l. Provide technical assistance, equipment and supplies through the United States Army Corps of Engineers (USACE) as required, in support of PHS to accomplish temporary restoration of damaged public utilities affecting public health.

3. Department of Justice
   a. Assist Federal health and medical response operations in victim identification. This support will be coordinated through the Federal Bureau of Investigation (FBI) Disaster Squad located at FBI Headquarters in Washington, D.C.
   b. Provide State and local governments legal advice concerning the identification of the dead.
   c. Provide OASH/OEP with relevant intelligence information of any credible threat or other situation that could potentially threaten public health. This support will be coordinated through FBI Headquarters in Washington, DC.
   d. Provide communications, transportation, and other logistical support to the extent possible. This support is provided through the FBI.
4. Department of Transportation
   a. Assist in identifying and arranging for utilization of all types of transportation, such as air, rail, marine, and motor vehicle.
   b. Assist in identifying and arranging for utilization of United States Coast Guard (USCG) aircraft, in providing urgent

airlift support when not otherwise required by ESF #1 or the USCG.

c. Provide supplemental casualty distribution assistance from DOT resources subject to DOT statutory requirements.

d. Coordinate with the Federal Aviation Administration (FAA) for air traffic control support for priority missions.

5. Department of Veterans Affairs

a. Alert VA NDMS FCCs to activate NDMS area operations/patient reception plans; initiate bed reporting based on ASMRO instructions; and coordinate patient reception and management in those VA NDMS FCC areas where VA medical centers serve a s local NDMS FCCs.

b. Provide available medical support to assist in the support of State/local governments within the disaster area. Such services may include triage, medical treatment, and the utilization of surviving VA medical centers within the disaster area.

c. Provide available medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims.

d. Provide assistance in managing human remains including victim identification and disposition.

6. Agency for International Development, Office of U.S. Foreign Disaster Assistance

a. Provide assistance in coordinating international offers for health/medical support.

b. Provide communications support to the extent possible.

7. American Red Cross

a. Provide emergency first aid, supportive counseling, health care for minor illnesses and injuries to disaster victims in Mass Care shelters, ARC DFO, selected disaster clean-up areas, and other sites deemed necessary by the primary agency.

b. Supplement the existing community's health system subject to the availability of staff.

c. Provide supportive counseling for the family members of the dead and injured.

d. Provide available personnel to assist in temporary infirmaries, immunization clinics, morgues, hospitals, and nursing homes.

e. Acquaint families with available health resources and services and make appropriate referrals.

f. Provide blood and blood products through regional Blood Centers at the request of the appropriate agency.

g. Provide coordination for uploading of appropriate casualty/patient information from ESF #8 into the DWI System.

8. Environmental Protection Agency

Assist Federal health and medical response operations by providing technical assistance and environmental information for the assessment of the health/medical aspects of situations

involving hazardous materials.

9. Federal Emergency Management Agency
   a. Assist NDMS in establishing priorities for application of health and medical support.
   b. Assist in providing NDMS communications support.
   c. Assist in providing information/liaison with emergency management officials in NDMS FCC areas.
10. General Services Administration
   Assist Federal health and medical response operations by providing facilities, equipment, supplies and other logistical support including the acquiring of private sector ground and air transportation resources.
11. National Communications System
   Assist Federal health and medical response operations by providing communications support for medical command and control. This support will be coordinated through the Office of the Manager.
12. U.S. Postal Service
   Assist Federal health and medical response operations by providing air and ground transportation support.

VI. RESOURCE REQUIREMENTS

A. Assets Critical for Initial 12 hours The most critical requirements during the initial 12 hours of a major disaster will be medical response personnel, necessary medical supplies and equipment, transportation, logistical and administrative support, and communications systems support. The principal requirements will be:

1. The alerting and deployment of emergency response coordinators, National ESF #8 ERT, the Regional ESF #8 emergency response structure, and other necessary ESF #8 personnel.
2. The alerting and deployment of Federalized NDMS DMATs, DMORTs, and supporting military medical units to assist State/local authorities in the delivery of patient care to victims of the disaster and the provision of mortuary services as required. Patient care will probably be rendered under austere field conditions for casualty clearing, casualty staging, and during transportation.
3. Medical supplies (including pharmaceutical and biologic products) and equipment necessary to replace those damaged or destroyed by the disaster. Additionally, resupply will be needed for deployed DMATs/DMORTS, supporting military medical units, and State/local medical units providing patient care in the affected area.
4. Transportation support to include:
   a. Aircraft for transport of incoming medical response

personnel, supplies, and equipment;
b. Ground transportation for deployment of incoming assets within the disaster area;
c. Ground transportation and rotary wing aircraft for movement of casualties within the affected area;
d. Fixed wing short, medium, and long- range aircraft for patient evacuation from the disaster area;
e. Ground transportation and rotary wing aircraft for patient distribution within local NDMS patient reception areas; and
f. Aircraft for retrograde transport of medical response personnel and equipment following deactivation.

5. Logistic and administrative support including:
   a. One or more representatives of each ESF #8 lead/support agency to be located at or to be immediately available via telecommunications (as appropriate to support) to National ESF #8, Regional ESF #8, or within disaster area;
   b. One or more representatives of the lead agency to be located with the FEMA EST;
   c. One or more representatives of the lead agency to be located with the FEMA CDRG;
   d. One or more ERCs from OASH/OEP to deploy to the disaster area to assist Regional ESF #8 with emergency response coordination;
   e. One or more representatives at the Centers for Disease Control Emergency Response Coordination Group (CDC ERCG) facility in Atlanta, GA. to deploy to the disaster area to assist Regional ESF #8 with emergency response coordination;
   f. One or more representatives of National ESF #8 to deploy as required to assist Regional ESF #8 with emergency response coordination;
   g. Qualified personnel to establish, maintain, and operate communications systems;
   h. Clerical support personnel at the National ESF #8 and Regional ESF #8 centralized locations;
   i. Reference material including plans, directories, maps, etcetera necessary for coordination of medical and public health response; and
   j. Facilities adequate for the operation of the National ESF #8 and Regional ESF #8 on a 24-hour basis.
6. Communications systems including:
   a. Voice and data communications systems connecting National ESF #8 and Regional ESF #8, DOMS, ASMRO, local NDMS FCCs, FEMA EST, and the CDC ERCG;
   b. Voice communications with DMAT sponsors;
   c. Intra-regional voice communications systems connecting national, regional, State, and local officials

involved in immediate medical response operations; and
d. Communications required to support casualty clearing, aeromedical staging, and patient evacuation and reception operations.

B. Assets Required for Continuing Operations The assets required for the initial 12 hours will also be required for the remainder of the response period. Requirements may be modified (increased or decreased) depending on verification of initial requests for assistance, confirmation of casualty and damage estimates/locations, and the time required for medical and public health (including environmental health) response. The discovery of previously undetected damage, hazardous conditions, or other requirements could also modify the Federal medical and public health response. Some significant increases in public health and mental health assistance will probably be required following the initial response period and will probably need to continue well into the recovery and restoration phases. Such assistance may include the provision of environmental health services for shelters.

VII. REFERENCES

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2. Public Health Service Act, 42 U.S.C. 217; 42 U.S.C 243(c)(1); 42 U.S.C. 243(c)(2); 42 U.S.C. 319.
3. Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (P.L. 96-510).
4. National Security Decision Directive 47, July 1982.
5. Executive Order 12656, November 18, 1988.
6. Executive Order 12657, November 18, 1988.
7. DOD Directive 6010.17, National Disaster Medical System, December 28, 1988.
8. DOD Directive 3025.1, Use of Military Resources During Peacetime Civil Emergencies within the United States, its Territories, and Possessions, May 23, 1980.
9. 55 FR 2885, Office of the Assistant Secretary for Health; Statement of Organization, Functions, and Delegations of Authority, January 29, 1990.
10. 55 FR 2879, Office of the Secretary; Statement of Organizations, Functions, and Delegations of Authority, January 29, 1990.
11. "Public Health Service Disaster Response Guides," May 1987.
12. "Facts on the National Disaster Medical System," January 1991.
13. "National Disaster Medical System - Concept of Operations," January 1991.
14. "National Disaster Medical System - Operations Support Center Manual," April 1991.

15. "National Disaster Medical System - Federal Coordinating Center Guide," March 1985.
16. "National Disaster Medical System - Disaster Medical Assistance Team Organization Guide," July 1986.
17. "The Public Health Consequences of Disasters," Centers for Disease Control, U.S. Public Health Service, September 1989.

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